DOCUMENT RESUME

ED 284 850 SP 029 216

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TITLE The Impact of the Seaside Health Education Conference on Middle School Health Programs in Oregon.
PUB DATE 87
NOTE 20p.; Paper presented at the National Convention of the American Alliance for Health, Physical Education, Recreation and Dance (Las Vegas, NV, April 13-17, 1987).
PUB TYPE Reports - Research/Technical (143) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Conferences; *Health Education; *Inservice Teacher Education; Middle Schools; Physical Fitness; Program Effectiveness; *Program Evaluation; Role Models; Well Being
IDENTIFIERS Seaside Health Education Conference OR

ABSTRACT

This paper presents an evaluation of the Seaside Health Education Conference (SHEC) that, for ten years, has been held yearly for the purpose of promoting health education in Oregon schools by providing in-service programs for teachers. Each school district attending the SHEC comes as a team composed of health educators, other teachers, administrators, staff, parents, and/or school board members. During the week each team develops an "action plan" for promoting healthy lifestyles. The "action plan" demonstrates how the district will take back the concepts learned at the conference and implement them in their schools. A description is given on how an evaluation of SHEC was conducted at 14 middle schools in an attempt to measure the school and district-wide impact on school health programs of the conferences over the past decade. The overall results of the evaluation indicated schools that regularly attending the SHEC have a greater wellness emphasis and a stronger health program than those schools not attending the conference. Data tables and a two-page bibliography are included. (JD)

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THE IMPACT OF THE SEASIDE HEALTH EDUCATION CONFERENCE ON MIDDLE SCHOOL HEALTH PROGRAMS IN OREGON

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INTRODUCTION

With the first Surgeon General's Report on Smoking and Health in 1964, the link between lifestyle and health was positively demonstrated. Since that time studies such as the Stanford Three Community Field Study (MacCoby, Farquhar, Wood, and Alexander, 1977) and the North Karelia Finland Study (Puska, Kotte, Tuomilehto, and Nissinen, 1979) have validated the interaction between lifestyle and health.

Sehnert (1980) notes that a great interest health promotion has surfaced at almost every level of our nation. He states that the majority of diseases found in today's society are a result of lifestyle choice behavior. In other words, people influence their health to a large degree by the lifestyle choices they make. Through education they gain an awareness of choice alternatives and the potential health consequences of each alternative.

With an increased emphasis on health promotion, the obvious place to start motivating individuals is in the schools. Since health habits and values are formulated during early years, the schools are of great significance in the formulation of positive lifetime habits and values (Laing, 1981). The Surgeon General of the United States has said "No group is more able than school teachers to provide...instruction that can help young people make decisions that promote good health" (Surgeon General's Report, 1979). Du Shaw (1984) feels that a failure to capitalize on the schools as a source of health habit and attitude development would be a tragedy.

SP 09620 9/16

Of critical importance in the development of health promotion programs in the public schools, is the attitude and preparation of the teacher. The educator needs to be a vehicle to show students how to adopt and maintain healthy behaviors (Hochbaum, 1978). As the emphasis on health and wellness in the schools grows, curricular changes need to be addressed. Teachers need to be competent in not only the traditional topics but also in the areas emphasized by a wellness approach. Expanded curricula and activities to teach these areas are also needed.

One way to help teachers obtain knowledge and skills to do wellness programs is through in-service programs and conferences. Weiss (1978) and Stannard (1982) postulate that professional conferences and inservice programs are excellent sources of curricular and activity oriented information for teachers. They report that such conferences provide a real impetus for teachers to improve their programs. Shapiro (1981) and Gabel & Rubba (1979) have found that inservice training can facilitate positive changes in teachers' attitudes and re-excite them about their chosen subject area. The recharged educators can then influence positive changes in students, and even their colleagues.

An outstanding example of a professional conference that deals with health is the Seaside Health Education Conference (SHEC) which occurs yearly in Seaside, Oregon. Dosch and Paxton (1981) point out that the SHEC is the main reason for the explosion of enthusiasm for health in Oregon schools.

For ten years, the SHEC has been involved in promoting health in the schools of Oregon. Sessions at the SHEC encourage teachers to integrate wellness into the entire school program. Teachers learn the importance of being health role models and

practice a healthy lifestyle while at Seaside. In addition, they gain information on methods and activities to present various health topical areas to their students.

Two key components of the entire week long conference, however, are the use of teams and the development of an action plan. Each school district that attends the SHEC must come as a team (no individuals are allowed). Teams can be made up of health educators, other teachers, administrators, staff, parents, and/or school board members. Each team is required to develop an "action plan" during the week. The "action plan" shows how the district will take back the concepts learned at the conference and implement them into their schools (Drolet and Davis, 1984).

Due to the excellent reputation of the SHEC, the Seaside concept is now being spread to other states. No less than 17 states (Alaska, California, Georgia, Idaho, Iowa, Kansas, Maine, Michigan, Washington, Montana, New Hampshire, New Mexico, North Dakota, Ohio, South Carolina, Vermont, and Virginia) have received grants to attend the conference. These teams have taken their "action plans" and started similar wellness conferences for educators in their repective states (Tritsch, 1986). Largely because of the SHEC, Oregon is seen as a model state for school health education (Dosch and Paxton, 1981).

PURPOSE AND SIGNIFICANCE

As the SHEC focuses on encouraging the schools to make health with a wellness emphasis an important part of the total school curriculum, this study attempted to determine if schools which had made a real commitment to the SHEC, had more wellness oriented programs than schools which chose not to attend the

SHEC. Variables in the study focused on student attitudes toward health classes, nonhealth teacher attitudes toward health, and the number of health-related activities offered by the school and the number of students that participated in those activities. In short, the study examined whether or not the SHEC has had an impact on the health curriculum and programs in those schools that have attended the conference regularly.

Due to the fact that 17 states have sent teams to the SHEC and have developed similar health conferences, this study takes on added significance. The SHEC is the oldest of the state wellness conferences. Data collected from Oregon schools has potential predictive value for the long term influences of such wellness conferences on health programs in schools in other states.

METHODOLOGY

In order to determine the impact of the SHEC on school health programs, site visits were conducted at 14 middle schools (grades 6-8) around the state of Oregon. Seven of the schools (called attenders) had sent teams to the SHEC at least three times since 1981, while the other seven (called nonattenders) had either sent teams less frequently or not at all. Schools were randomly selected from groupings stratified by geographic region. Attender and nonattender schools were represented in equal numbers and represented similar size, locale, and student SES within each region. No school district within a region was represented by more than one middle school.

From each school, 20 minute individual interviews were conducted with the principal and two health teachers (if the

school had that many) to determine the current nature of the school's health program. Interviews were conducted using a semi-closed ended format to assure that the same questions were asked of each interviewee and to make data collection easier and more quantifiable. Interview questions were validated by expert panel prior to use.

For the purposes of measuring school-wide impact of the SHEC, surveys were distributed to one randomly selected nonhealth class of sixth graders, one nonhealth class of seventh graders, and one nonhealth class of eight graders in each school. The surveys measured the students attitudes toward health classes and asked which schoolwide health-related activities they had participated in since they had been in middle school.

The attitude measure was a modified version of Silance and Remmers' (1934) instrument to ascertain attitudes about various subject areas. The measure, a Thurstone type scale, consisted of 44 statements about health classes. The student circled the number of the statements with which she/he agreed. Each statement was assigned a scale value from 10.6 (the most positive) to 0.6 (the most negative). A student's attitude score was represented by the median of the scale values of the items endorsed by that student. The instrument was validated for middle school students by the researcher in a pilot study.

The student health activity participation survey was developed by the researcher. It consisted of 20 "Have you" statements concerning possible health-related activities students may have participated in while in middle school. Students were asked to check the statements that represented activities they had engaged in. Space was provided for students to list

addditional activities not mentioned in the survey. Frequencies were tabulated for each item and attender school student responses were compared with nonattender school responses using chi square.

In addition, nonhealth teachers were surveyed to determine the diffusion of health-related information throughout the school. They were asked to evaluate their school's health program in six areas: (a) fitness; (b) eating well; (c) health practices; (d) enjoying life; (e) relating to others; and (f) global awareness. The questionnaire was adapted from an instrument used by the Northwest Regional Labs in Portland to evaluate a health education program in The Dalles, Oregon.

The questionnaire asked the nonhealth teacher to rate the degree of various school health practices and/or opportunities provided by that school's health program. Each question had a potential rating from 1 to 5 (with 5 representing a high level of achievement). Scores were tabulated for each of the six areas and an overall rating for each area was determined. High ratings in any area meant that the nonhealth teacher felt their school was doing a particularly good job in educating students in that area. Ratings were compared between attender and nonattender schools using a t-test.

As most of the data collected in the study was self-report, an unobtrusive instrument was developed to validate the interview and survey information. Health-related posters displayed around the school were counted, number and frequency of student use of health-related library books was noted, the number of outside agency materials utilized and the number of outside health speakers used were counted, the school calendar was surveyed for

actual health-related activities occurring at each school, menus were checked for the variety of choices offered to students, and the number of vending machines and frequency of snack breaks (if any) were recorded.

Data were analyzed by comparing the results of attender schools with those from nonattender schools. t-Tests and chi-square were the statistics used for comparison of groups.

RESULTS

Because site visits were utilized to collect data, the response rate for all surveys and interviews was 100%. Two schools had only one person teaching health, but all had principals and housed classes of students in grades 6 through 8.

The majority of SHEC workshops feature a wellness emphasis focusing on exercise/fitness, safety, nutrition, and stress management. To determine if this emphasis is carried back to the schools, principals and health teachers were asked to describe the health program emphasis in their respective schools.

As can be seen from table 1, six of the seven attender principals reported a wellness emphasis while only two of the seven attender principals noted a wellness emphasis. These differences were significant at the 0.05 level. Based on principal responses, SHEC attender schools do have a greater wellness emphasis.

Similar findings can be seen in table 1 with regard to the responses of health teachers. Ten of thirteen attender school health teachers report a wellness approach while only three of thirteen nonattender school teachers use a wellness approach. Based on chi-square analysis significant differences (p=.023)

exist between attender and nonattender health teachers with regard to program emphasis. Attender school health programs do have more of a wellness emphasis.

Teachers were also asked to rate the amount of time they spent on each of 13 health topical areas from 1-5 with 5 being high. t-Test results (table 2) comparing mean ratings between attender and nonattender groups for each of the topical areas indicated that SHEC attender schools have a curriculum which spends more time on nutrition (p=.019), exercise/fitness (p=.013), environmental sensitivity (p=.002), safety (p=.014), and hygiene (p=.043). None of the nonattender schools spent significantly more time than attenders on any of the surveyed topical areas. The findings confirm the analysis from table 1; SHEC attender schools spend more time on the wellness topics.

As participants at the SHEC are encouraged to return to their schools and become change agents for wellness, the study also measured diffusion of health into the total school program. This was accomplished by asking three nonhealth teachers from each school to rate the emphasis on health in their school's program. Attender school nonhealth teachers evaluated their school higher than did their counterparts from nonattender schools in all six areas (table 3). Significant differences were found in several areas: fitness (p=.001), global awareness (p=.001), relationships with others (p=.011), and health practices (p=.024).

A major goal of the SHEC is to provide teachers with the skills necessary to excite students about health and to promote positive attitudes and behaviors. To determine if this goal has been met, a student attitude survey was used. Results from the

student attitude survey (table 4) showed that attender school students had significantly higher attitudes about their health classes than did nonattender school students (p=.00). The mean response value of 7.58 for attender students translated to a health attitude of "more health classes should be offered." Nonattender school students' mean attitude response value of 6.72 translated to "health is not boring." Both of the response means indicated general responses above a neutral feeling (5.5); however, attender school students responded more consistently in a positive direction than nonattender school students, as evidenced by a lower standard deviation.

A second portion of the survey asked students to check those health activities they had participated in since being enrolled in middle school. For all activities but one, "taking a class that teaches about drugs and decisions faced concerning drug use," a greater percentage of attender school students had taken part in activities than nonattender school students (table 5). Greater than half of the students from both groups had participated in 10 of the 20 listed activities.

Significant differences were found between attender and nonattender groups in 9 of the 20 activities listed in table 5. Attender school students had the greater proportion in all cases. Of note, however, is the fact that 8 of the 9 activities which were significantly different were more academic in nature. The only one with a behavioral emphasis was "had blood pressure checked." The remainder of the activities which were behavioral in nature were statistically the same for attender and nonattender school students.

DISCUSSION

Several findings tend to support the fact that the SHEC has made a difference on school health programs in Oregon. As the SHEC is a wellness conference, the majority of the presentations and demonstrations deal with exercise/fitness, nutrition, safety, and stress management. Attender schools were found to offer significantly more coursework in these areas with one exception. Differences did not exist in the area of stress management. All middle schools surveyed, attenders and nonattenders alike, offered little in that area. Most teachers felt stress management was better left until high school age.

Interviews with principals and health teachers from each group of schools gave evidence which substantiated the program content differences between groups. Both principals and health teachers from attender schools reported a significantly greater wellness orientation than did principals and teachers from nonattender schools. Although this finding does not substantiate the impact of the SHEC in a cause-effect sense, the fact that the responses indicate course emphasis since 1980 helps establish at least a correlational link as to the conference impact on curricular direction.

Apart from curricular emphasis, schools that had sent teachers to the SHEC had more student participation in health-related activities both in and out of school. It should be noted, however, that attender school students had a significantly higher participation in only 9 of 20 activities surveyed. Consequently, attender school students and nonattender school students participate in a statistically equal number of

activities in greater than half of the items on the questionnaire. Overall, the SHEC has not influenced the majority of school activities surveyed in this study to the extent that might be hoped for by the organizers, but it does seem to have had a positive influence on student activity participation.

In a similar vein, students from attender schools had significantly more positive attitudes about health classes than their counterparts from nonattender schools. As the students from attender and nonattender schools did not differ demographically or geographically, the reason for the increased level of participation and more positive attitudes toward health classes of attender school students may have been the result of the health opportunities provided by their school district and particularly the health teachers within the district. Further, the SHEC may have stimulated the teachers and districts to provide these opportunities.

The SHEC trains participants to develop a school-wide health awareness and health program. The fact that nonhealth teachers from attender schools evaluated their school's overall health program as significantly better in teaching about the importance of fitness, good health practices, relating to others, and global awareness, than did similar teachers from nonattender schools, helps substantiate that the health program in the SHEC attender schools is viewed as a positive influence on the total school program by teachers outside the health field. By impacting nonhealth teachers, the school health program of attender schols has a much better chance of creating an atmosphere that is conducive to health attitude and behavior change in students and

other school personnel. The health program also is seen as being a positive and integral part of the total school curriculum.

In conclusion, overall results of this study show that schools that regularly attend the SHEC have a greater wellness emphasis and a stronger health program than those schools not attending the conference. Caution must be used, however, in concluding that the SHEC caused these differences. Since cause and effect can not be established, an alternative explanation might be that schools with a greater health emphasis and stronger health programs attend the SHEC, while those placing less emphasis on health do not. Based on anecdotal evidence this would not seem to be the case. Numerous schools attending the SHEC report that their programs were turned around by the conference and many of the schools not attending would love to attend but are prohibited due to financial reasons.

The SHEC has had a positive impact on public school health programs in the state of Oregon. Health program attitudes of students, teachers, and administrators have also been positively influenced. With the addition of out-of-state teams to the SHEC, it is hoped that the Seaside concept can be transplanted to other states. As these states establish their own Seaside-type conferences, their evaluations will help establish the validity of the SHEC.

TABLE 1. Responses of Principals and Health Teachers About School Health Program Emphasis

Principals				
School Health Program Emphasis	Nonattenders n = 7	Attenders n = 7	X^2	p
Disease	4	0	6.00	.050
Wellness	2	6		
Comprehensive	1	1		
Health Teachers				
School Health Program Emphasis	Nonattenders n = 13	Attenders n = 13	X^2	p
Disease	7	2	7.55	.023
Wellness	3	10		
Comprehensive	3	1		

TABLE 2. Health Teacher Topical Area Emphasis Rating for Health Curriculum

Topical Area	Nonattender n = 13	Attender n = 13	t	p
Environmental sensitivity				
$\bar{x}$	2.539	3.539	3.54	.002
(SD)	(.660)	(.776)		
Exercise/fitness				
$\bar{x}$	3.462	4.385	2.69	.013
(SD)	(1.050)	(.650)		
Safety				
$\bar{x}$	3.000	3.923	2.65	.014
(SD)	(.913)	(.862)		
Nutrition				
$\bar{x}$	3.154	3.923	2.51	.019
(SD)	(.801)	(.760)		
Hygiene				
$\bar{x}$	2.846	3.462	2.14	.043
(SD)	(.801)	(.660)		
First aid/CPR				
$\bar{x}$	3.231	4.077	1.83	.079
(SD)	(1.092)	(1.256)		
Drugs/alcohol				
$\bar{x}$	4.308	3.692	-1.66	.111
(SD)	(.855)	(1.032)		
Stress management				
$\bar{x}$	3.000	3.385	1.05	.306
(SD)	(.913)	(.961)		
Anatomy/physiology				
$\bar{x}$	3.385	3.846	1.04	.309
(SD)	(1.261)	(.987)		
Disease				
$\bar{x}$	3.608	3.385	-.91	.340
(SD)	(.947)	(.870)		
Self-responsibility for health				
$\bar{x}$	3.615	3.846	.67	.512
(SD)	(.870)	(.899)		
Family life				
$\bar{x}$	3.231	3.385	.44	.666
(SD)	(.927)	(.870)		
Mental health				
$\bar{x}$	3.692	3.539	-.39	.698
(SD)	(1.032)	(.967)		

NOTE: 1 = low emphasis; 3 = no change since 1980; 5 = high emphasis.

TABLE 3. Nonhealth Teacher Evaluation of Total School Health Program

Area Evaluated	Average Non-Attender School Rating n = 21	Average Attender School Rating n = 21	t	p
Fitness				
$\bar{x}$	2.471	3.295	3.78	.001
(SD)	(.644)	(.763)		
Global awareness				
$\bar{x}$	3.138	3.886	3.68	.001
(SD)	(.759)	(.539)		
Relating to others				
$\bar{x}$	3.243	3.762	2.67	.011
(SD)	(.675)	(.581)		
Health practices				
$\bar{x}$	3.205	3.700	2.35	.024
(SD)	(.699)	(.669)		
Nutrition				
$\bar{x}$	2.624	3.005	1.82	.076
(SD)	(.613)	(.735)		
Life enjoyment				
$\bar{x}$	2.814	3.233	1.78	.082
(SD)	(.727)	(.794)		

NOTE: 1 = low; 5 = high.

TABLE 4. Student Attitude Ratings About Health Courses

	Mean Nonattender School Student Attitudes n = 447	Mean Attender School Student Attitudes n = 340	t	p
$\bar{x}$	6.72	7.58	5.09	.00
(SD)	(2.54)	(2.02)		

NOTE: 10.6 = highest attitude rating.
0.6 = lowest attitude rating.

TABLE 5. A Comparison of the Number of Students Participating in Designated Health Activities

Activity	Nonattender n = 450	Attender n = 366	X^2	p
Taken a first aid/CPR class	126	205	64.5290	<.001
Chosen to take a health class	41	77	22.2580	<.001
Had blood pressure checked	268	270	17.5300	<.001
Read a health-related book	290	281	14.0280	<.001
Read a health-related pamphlet at school	229	229	11.3380	<.001
Taken a health class from a community group such as the American Cancer Society	23	34	4.8000	.028
Taken a required class	315	281	4.3680	.037
Attended a health faire	37	47	4.1770	.040
Watched a health-related TV show	292	290	3.7370	.050
Increase in amount of exercise for at least two months	174	164	2.8900	.089
Read a health-related newspaper article	229	206	2.1490	.143
Had eyes and/or ears checked	349	300	2.1490	.143
Altered diet to use less sugar	163	143	.5830	.445
Altered diet to eat more fiber	77	71	.5660	.452
Listened to a radio program on a health-related topic	124	108	.2880	.591
Taken a class that teaches about drugs and decisions concerning drug use	255	200	.2580	.612
Listened to a speaker on a health-related topic at school	266	223	.2070	.649
Altered diet to eat less fat	152	130	.1990	.655
Adopted a plan to manage stress	52	38	.1760	.675
Watched a film showing a health topic in a class other than a health class	317	258	.0003	.950

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